MEDICAL CARE ADVISORY COMMITTEE
PUBLIC HEARING

Minutes of the June 20, 2013 Meeting

IN ATTENDANCE

PRESENT: Lincoln Nehring, Mauricio Agramont, Kevin Burt, Jackie Reudo for Rebecca Glathar, Matthew Slonaker, Jason J. Horgesheimer, La Val B. Jensen, Greg Myers, Tina Persels, Andrew Riggle, E. David Ward, Mark Brasher, Debra Mair, Michael Hales

EXCUSED: Russ Elbel, Warren V. Walker, Rebecca Glathar, Michelle McOmber, Pasu Pasupathi

ABSENT: LaPriel Clark

STAFF: Dr. Kim Michelson, Dr. Caryn Slack, Jeff Nelson, Rick Platt, Tracy Luoma, Emma Chacon, Tonya Hales, Nate Checketts, Sheila Walsh-McDonald, Josip Ambrenac, Gayle Coombs

VISITORS: Christie Johnson, Kristen Holt, Mark Ward, Doug Springmeyer, Joyce Dolcourt, Kris Fawson, W. E. Cosgrove

1. **Welcome** – Lincoln Nehring

Chairman Nehring called the meeting to order at 4:05 p.m. and welcomed everyone to the meeting.

Approve Minutes of April 18th, 2013 Meeting

Chairman Nehring then asked for a motion in regard to approving the minutes from the last meeting. Andrew Riggle made the motion to approve the minutes from the last meeting and everyone agreed. The minutes were approved.

2. **Budget Update** – Rick Platt

Rick went over the changes for the last two months in the budget. There were no questions or comments.

3. **PCP/VFC Enhanced Rate Update** - John Curless

John said that what is now in the managed care methodology for the plans is based upon a 102% rate level and that using a Fee-For-Service method for the ACOs did not make sense. The calculated payment to the ACOs does not necessarily equate to what the ACO should pay the providers to ensure they are paid at the Medicare fee levels.

On the FFS side, the state plan amendment has been approved. Coverage and Reimbursement is working on a query to identify claims eligible for reimbursement. He said they hope to have the payment in provider's accounts by July 2nd. This would be for the first quarter of 2013. Later in July they will refresh the data and then make the second quarter payment.

John said they currently have 1,150 providers who have self-attested and have been verified to be eligible for the enhanced rate for both 2013 and 2014.

- 266 are eligible for 2013 only at this time
- 74 providers did not have board certifications and did not meet the 60% coding requirement
- 78 claimed to have board certifications had not yet provided
- 66 were non-physicians
- many submissions were also not 'self-attestations', they were completed by others

Postings of this information continue to be published on the Medicaid website as noted in the recent quarterly MIB. The number of self-attestations has diminished over the last few months.

Dr. Cosgrove asked if this enhancement has resulted in an increase in participating Medicaid providers. John stated that this was not something that had been monitored. Michael added that this could be looked at as the Department does capture information on the number of enrolled providers routinely, however their motive for enrolling would not be known.

A question was also asked to see if an updated self-attestation report could be provided by the end of the quarter/fiscal year. John stated that the Department could work to accommodate that.

3. **<u>Quality Measures Workgroup Update</u>** – Emma Chacon

Emma then gave the quality measures workgroup update. She mentioned the web site is shown on the back of the document that was handed out in regard to this. Emma went over the different pages in the handout. She said they now have about 100 people on the list. Emma went over the principles to consider which are shown below:

- Foster accountability
- Relevance to population served
- Fair/appropriate to those being measured
- Practicality of measuring

Emma then went over the beneficiary demographics shown on page 4 which are shown below:

- Newborns and Infants
- Children
- Pregnant Mothers
- Special Needs
  - Children
  - Adults

Page 5 of the handout discussed measurements already being conducted. (HEDIS, CAHPS, CMS child/adult measure, HIT, Meaningful Use, etc.) She mentioned Dr. Doug Hasbrouck who assisted them in coming up with a grid and looking at different things in regard to this (preventative, chronic, acute, access, satisfaction, etc.) Emma discussed the considerations for measures that are not HEDIS or CAHPS. 25 specific measures have been identified for possible inclusion in the contracts and they will be reporting on them and publishing them on their web site.

Part of the workgroup meetings has been to review what other states have chosen to measure, with some focus on what Oregon has done with its 'coordinated care organizations' which integrate behavioral, physical and oral care.

Some of the considerations the workgroup has been tackling are what measures are appropriate for Utah, what the data sources might be and seeing if there are any concerns with the data sources. The Office of Health Care Statistics has also been assisting with analysis recommendations and helping work through logistical issues. Emma said all of their meetings are posted on their web site and everyone is invited to attend if they want to (Next meetings are on 7/15 and 7/29).

Three additional areas are also slated for assessment related to the integration of behavioral and physical health. HB57 passed this last session requiring coordination plans. An additional series of meetings was developed specifically for this, beginning next Wednesday, (6/26). There are also requirements related to HB141 on Medicaid ER and Primary Care aimed to try and reduce non-emergent use of ER's. The Department is to submit rulemaking to establish performance measures on how ACO's are reducing non-emergent ER use. (Diversion plans, increasing access to primary care, community health centers, extending hours for the evening/weekends, increasing quality of care, etc.) In addition, the Department is to apply for Medicaid and CHIP amendments to increase co-pays for non-emergent ER use as well as to incentivize the ACO's for improvement in this area. A November deadline for rulemaking was provided.

Emma said they also want to look specifically at developing some quality measures for people with special health care needs. This process will begin in the August meetings.

4. **Expansion Workgroup/PCG Report Update** – Nate Checketts

Nate handed out a copy of a document in regard to this to everyone entitled "Public Consulting Group – Summary of Cost/Benefit Analysis". The full report can be found online at http://health.utah.gov/medicaid The five scenarios included in the analysis are:

Scenario 1 – Mandatory Only
Scenario 2 – Full Optional Expansion, Full Benefits
Scenario 3 – Full Optional Expansion, Benchmark Benefits
Scenario 4 – Partial Optional Expansion, Full Benefits
Scenario 5 – Partial Optional Expansion, Benchmark Benefits

He said that if we do the full expansion, the Federal Government said they would match this at 100% for the first three years, then decrease at a rate of 2% per year, but the lowest match rate would be 90%.

CMS also clarified that any partial expansion would only be eligible for the state's current FMAP rate. For Utah, this is typically around 70%. Scenarios 4 and 5 take this into consideration. 1, 3 and 10 year projections were provided. Some projections show short-term cost savings, however for 2017 and beyond, the State does end up assuming cost in some form.

Andrew Riggle asked that if the state chose not to expand, is the group between 100% and 138% of the poverty level eligible for insurance subsidies? This was previously stated to be a 'doughnut hole' in possible coverage. Nate stated that when the ACA was drafted, there were many authors and that these two parts were brought together near the end, but did contradict each other slightly. Additional information has been provided to state that flexibility has been given to provide coverage to this group either through expansion or insurance subsidies. Michael added that the premium subsidies are available for anyone between 100-400% of the poverty limit, however, should someone with extremely low income not be Medicaid eligible, they may be missed.

Dr. Cosgrove asked if mental health benefits were also in the benchmark benefits. Andrew Riggle and Michael both confirmed they were. Michael added that the 'alternative benefit package' included 10 essential benefits, with mental health included. There is also a condition that the 'alternative benefit package' be actuarially sound and comparable to the state's largest insurer, or insurance received by state employees, etc. In Utah, it is the S.T.A.R. plan offered to state workers, which is quite different from standard PEHP coverage. Nate added information on covered benchmark benefits is available on page 104 of the PCG report, but is broken down by Medicaid categories which can be confusing. Mauricio Agramont asked if any dental or oral health benefits were included in the essential benefit package. Nate replied that this was specified for children only.

Nate said in 2023, 60,000 children and parents would gain coverage through this process and an additional 123,000 parents and adults without dependent children would gain coverage for the optional groups. Michael asked if these figures included children already on CHIP moving to Medicaid. Nate replied that these were new children only.

The Governor's work group was then discussed and it was mentioned that they want community input in regard to this. The workgroup will be looking at the PCG report and other models such as charity care. Sub-groups have been created to look at proposals and will continue to convene. The next workgroup meeting is October 1, 2013. During the Governor's summit on September 26th is when Nate hopes these sub groups will report out on what they see as their options for the State.

5. **<u>Director's Report</u>** – Michael Hales

PCN Renewal Update

Michael said the PCN Program has been in place since 2002. Without action, the state's authority to continue this program would have expired on 6/30/13. Michael said we did not get a full three-year extension but we do have an extension through November of this year (11/15/13). This will give the State time to look more at the options, mainly the possibility of Medicaid expansion. CMS does have many concerns with the current structure of the PCN program, largely the enrollment cap as well as the partial benefit package it offers. With CMS, should any program end, typically a 6-month extension is provided to aid in the transition. The PCN program offers coverage for a population group that is not typically eligible for Medicaid, but could be part of the expansion group.

Chairman Nehring asked what this may mean for the future of the UPP program. Michael replied that this program is also part of the same 1115 waiver and its future is in question as well. However, it may be possible to preserve this portion of the waiver as the removal of an enrollment cap would not be too concerning at this time with its limited use.

Joyce Dolcourt asked what impact this view on enrollment caps might have on the home and community based waiver programs. Michael replied that the HCBS waivers are run under the 1915(c) guidelines where the PCN and UPP programs are 1115 waivers and would not be impacted. Chairman Nehring mentioned that PCN was paid for previously through the reduction of other benefits in other programs. Should PCN be discontinued, would the funding be restored to those programs? Michael added that this may be a discussion point should CMS not authorize the program in the future. Chairman Nehring followed up by asking how many people on PCN would not be eligible for the premium subsidy. Nate Checketts stated that approximately 77-78% of PCN recipients are under 100% FPL.

6. **Explanation of Public Hearing/Voting** – Michael Hales

Michael explained why we have these public hearings. The Governor develops his budget recommendations for the legislature annually and all Departments/Agencies are requested to put together a list for consideration. The MCAC is used to help create this list for the Health Department. A ballot will be provided in July to prioritize the recommendations of the speakers today.

7. **Public Hearing**

First Speaker – Dr. Caryn Slack

Dr. Caryn Slack discussed Elective Circumcision Coverage that they want to have covered under Utah Medicaid. A document on this was handed out to everyone and Dr. Slack went over the items in the document. The handout covered the current state, recent changes, fiscal impact and Utah Medicaid Policy Committee proposal in regard to this. This coverage was previously discontinued in September 2003 due to appropriations decrease. This coverage is needed as it addresses hygiene concerns and is much easier to do as a child. The CHEC committee continues to meet on a case by case basis to determine medical necessity. Michael asked why recommendations are made to have this be elective versus a medical necessity. Dr. Slack stated that there are many social and religious concerns likely preventing a universal recommendation.

Second Speaker – Joyce Dolcourt

Joyce said she was here representing the LCPD, Legislative Coalition for People with Disabilities. She passed out a document in regard to the Medicaid Budget for FY 2015 Building Block Recommendations and went over what was in the document. Joyce stated she's supporting the continuation of the Transition Program which allows a limited number of individuals each year to move from Intermediate Care Facilities for Individuals with Intellectual Disabilities to HCBS waiver programs. In FY13 this is slated to assist approximately 15 people, and an estimated 16 people in FY14. Joyce said they are asking again that there be funding for this. She would like this included in the building block request for utilization and caseload growth.

Chairman Nehring asked if there were any Committee members that wanted to make any recommendations. Jackie Reudo, who was attending the meeting today in place of Rebecca Glathar, mentioned some things she felt were needed and that we should provide dental care for adults. A strong tie is present between dental and physical health that has such limited coverage currently. There is also a concern for job seekers who may have significant cosmetic/dental issues as they may be unattractive for employers to hire.

Chairman Nehring then mentioned that he feels we should expand Medicaid to cover more adults and supports the full optional Medicaid expansion. He said he would also like the Committee to look at the five-year waiting period that legal immigrants have to wait before they can receive Medicaid benefits, other than emergency care. Sponsors who are required to provide care does create a conflict. Mauricio added that in a lot of situations, some members of the family are eligible, for example, one sibling was born in the US while the others are legal immigrants. They are able to access care immediately which is a concern for families.

Chairman Nehring then mentioned the 12-month continuous eligibility for children in Medicaid. He said he wants to make sure children get covered and are enrolled. Losing coverage periodically can cause a lot of concerns for families and this would help prevent coverage gaps.

Michael then discussed the issues with pediatric dentistry and the risk-based capitation model about to be introduced. In the 2011 session, the legislature tasked the Department with developing an RFP to have dental care provided through a managed care model. Following that RFP, it was determined that the responding entities were not able to demonstrate that their cost models and provider networks were sufficient to meet the RFP requirements.

In 2012, the original bill sponsors asked why there were no contracts awarded and asked the Department to re-issue the RFP. It was posted and had 5 responders, 3 of which had higher cost-structures than the contract could allow. Also, in rural areas, provider panels did not appear adequate, but the Wasatch front areas did. Specialty care and general care were evaluated separately. Delta Dental and Premier Access were selected.

Initially they were selected to take over on 7/1/13, however this has been postponed until September due to operational issues, the allowance for existing providers to complete appointments which have already been scheduled and to allow the plans to disseminate information on their provider panel.

The payment structure and reimbursement rate to dentists is at the discretion of the plans. There are still many providers unsure if they will participate. This is presenting a concern where the plans must assure access.

Jason Horgesheimer said that what is coming down right now really concerns the dental group he is part of. The capitation model employed causes a lot of fiscal uncertainty for the providers. In a large number of instances, new Medicaid patients require extensive up-front work, sometimes in the $1200-$1500 range, however the proposed reimbursement from the plans is $9.50 per client per month. Jason feels that the state and plans may be saving money at the expense of dental providers who currently only receive about 40-45% of their usual and customary fees under FFS Medicaid. Payment assurance and participation in public health do help to off-set some of this reduction, but the reduction in reimbursement is very significant. There is also a concern in the quality of care that

patients may receive. Non-treatment or under-treatment may occur because of how low reimbursement rates are. This system also does not promote prevention in an effort to 'receive money for doing nothing'.

In regard to a capitation plan or fee-for-service plan, the question was asked as to how a person ends up on either one of these plans. Michael said the families are given the choice between the two plans. Premier Access is still fee-for-service in its reimbursement to its dentists. Michael said it is really up to Delta Dental and Premier Access to come up with the rates. Jason said the capitation rate plan has failed in many states. There were a lot of questions and comments in regard to this.

Chairman Nehring asked how provider adequacy was determined. Emma stated that 1 provider for every 600 individuals is required and that coverage is required for every 10 mile radius. She also added that contacts were made to other states that have employed this model and that many positive reports were received, adding that the addition of case management has been a tremendous benefit. Michael added that a CMS report is required and they will also complete an analysis of access.

Emma stated that one plan is very close to having a complete provider panel, the other still has some work to do. Mauricio asked if this will cause a lot of children to have to see a general dentist instead of a pediatric dentist. Jason said this is correct and is a concern for him as well. He also added that he feels the Department is doing a great job of managing administrative costs already and is concerned about the for-profit aspect both of these plans have.

Jason said they are really just trying to be able to take care of these children. Andrew said he feels that if there are concerns that these concerns need to be directed to the Legislature. He asked would it be useful or appropriate for the members of the MCAC to draft a letter expressing concerns in regard to this and send it to the Legislature. He said we should let them know that this issue is important and can these concerns be considered by one or more Committees as an agenda item. Michael said on July 9th, this is on the agenda for the Health Committee.

It was asked if it is too late for the Health Department to make any changes on this. Emma explained some things that were going on now in regard to this question. She said they could tell the plans that we have to delay on this for a while. Chairman Nehring said we will bring this issue back to the July MCAC Meeting to discuss this. Kris Fawson said that since this is being discussed again on the July 9th Appropriations Committee, the MCAC should do a letter or something before then and send to them. Kris also asked if the plans had a maximum profit margin they could receive as a contract condition. Emma said that was not dictated in the agreement. Jason said he would like to delay this now and Chairman Nehring said we will discuss this again at the July MCAC Meeting and we will vote on our building blocks.

Chairman Nehring thanked everyone for coming today and Andrew made the motion to adjourn and everyone agreed. The meeting was adjourned at 6:15 PM